

		FOR OFF USE					

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**2000**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2000)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0038794</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>The Plum Grove of Palatine</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/00</u> to <u>12/31/00</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
<b>Address:</b> <u>24 S. Plum Grove Road</u> <u>Palatine</u> <u>60067</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
<b>County:</b> <u>Cook</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____	
<b>Telephone Number:</b> <u>847-358-0311</u> <b>Fax #</b> ( ) _____		<b>Paid Preparer</b> (Signed) <u>See Attached Accountant's Report</u> (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>Mendel S. Schneider &amp; Associates, C.P.A., P.C.</u> <u>6600 Lincoln Ave., Suite 330, Lincolnwood, IL 60712</u> (Telephone) <u>847-675-9311</u> <b>Fax #</b> <u>847-675-9343</u>	
<b>IDPA ID Number:</b> <u>36-3898623</u>		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b> <b>Phone # (217) 782-1630</b>	
<b>Date of Initial License for Current Owners:</b> <u>08/01/93</u>			
<b>Type of Ownership:</b>			
<input type="checkbox"/> <b>VOLUNTARY, NON-PROFIT</b> <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust <b>IRS Exemption Code</b> _____		<input checked="" type="checkbox"/> <b>PROPRIETARY</b> <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> <b>GOVERNMENTAL</b> <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>Mendel S. Schneider</u> <b>Telephone Number:</b> <u>847-675-9311</u>			

Facility Name & ID Number The Plum Grove of Palatine# 0038794 Report Period Beginning: 01/01/00 Ending: 12/31/00

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>69</u>	Skilled (SNF)	<u>69</u>	<u>25,254</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>69</u>	TOTALS	<u>69</u>	<u>25,254</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,494</u>	<u>1,384</u>	<u>399</u>	<u>3,277</u>	8
9	SNF/PED					9
10	ICF	<u>5,977</u>	<u>12,460</u>		<u>18,437</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>7,471</u>	<u>13,844</u>	<u>399</u>	<u>21,714</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 85.98%D. How many bed-hold days during this year were paid by Public Aid?  
\_\_\_\_\_  
(Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 08/01/93

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 08/01/93 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number  
of beds certified 5 and days of care provided 399Medicare Intermediary Administar

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31 Fiscal Year: 12/31

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number

The Plum Grove of Palatine

# 0038794

Report Period Beginning:

01/01/00

Ending:

12/31/00

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	122,431	6,810	5,005	134,246		134,246		134,246			1
2	Food Purchase		71,354		71,354	(3,500)	67,854		67,854			2
3	Housekeeping	50,981	33,513		84,494		84,494		84,494			3
4	Laundry	16,200	8,850		25,050		25,050		25,050			4
5	Heat and Other Utilities			42,592	42,592		42,592		42,592			5
6	Maintenance			44,276	44,276		44,276		44,276			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	189,612	120,527	91,873	402,012	(3,500)	398,512		398,512			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			1,800	1,800		1,800		1,800			9
10	Nursing and Medical Records	912,186	71,982	3,990	988,158		988,158		988,158			10
10a	Therapy											10a
11	Activities	39,796	5,224	2,851	47,871		47,871		47,871			11
12	Social Services	14,233			14,233		14,233		14,233			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	966,215	77,206	8,641	1,052,062		1,052,062		1,052,062			16
	<b>C. General Administration</b>											
17	Administrative	108,243			108,243		108,243		108,243			17
18	Directors Fees											18
19	Professional Services			18,803	18,803		18,803		18,803			19
20	Dues, Fees, Subscriptions & Promotions			16,924	16,924	21,771	38,695	(11,850)	26,845			20
21	Clerical & General Office Expenses	28,236	19,945	22,034	70,215		70,215	(675)	69,540			21
22	Employee Benefits & Payroll Taxes			193,023	193,023	(18,271)	174,752		174,752			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,404	5,404		5,404		5,404			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			40,522	40,522		40,522		40,522			26
27	Other (specify):*											27
28	<b>TOTAL General Administration</b>	136,479	19,945	296,710	453,134	3,500	456,634	(12,525)	444,109			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,292,306	217,678	397,224	1,907,208		1,907,208	(12,525)	1,894,683			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

Page 4

Facility Name & ID Number      The Plum Grove of Palatine

#0038794

Report Period Beginning:

01/01/00

Ending:

12/31/00

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			29,853	29,853		29,853	44,986	74,839			30
31	Amortization of Pre-Op. & Org.							25,650	25,650			31
32	Interest							179,943	179,943			32
33	Real Estate Taxes			165,873	165,873		165,873		165,873			33
34	Rent-Facility & Grounds			221,377	221,377		221,377	(221,377)				34
35	Rent-Equipment & Vehicles			10,506	10,506		10,506		10,506			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			427,609	427,609		427,609	29,202	456,811			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			37,882	37,882		37,882		37,882			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			37,882	37,882		37,882		37,882			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,292,306	217,678	862,715	2,372,699		2,372,699	16,677	2,389,376			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name &amp; ID Number The Plum Grove of Palatine

# 0038794

Report Period Beginning: 01/01/00

Ending: 12/31/00

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(13,144)	30		9
10	Interest and Other Investment Income	(9,960)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(675)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(11,850)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (35,629)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	52,306		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 52,306		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 16,677		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

NON-ALLOWABLE EXPENSES		Sch. V Line
	Amount	Reference
1	\$	1
2		2
3		3
4		4
5		5
6		6
7		7
8		8
9		9
10		10
11		11
12		12
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80		80
81		81
82		82
83		83
84		84
85		85
86		86
87		87
88		88
89		89
90 Total	0	90

## Summary A

# 0038794

**Report Period Beginning:**

**01/01/00**

**Ending:**

12/31/00

[illegible]

## Summary B

**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

[illegible]



Facility Name &amp; ID Number      The Plum Grove of Palatine

#      0038794

Report Period Beginning:

01/01/00

Ending:

12/31/00

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule		See Attached Schedule		Plum Properties	Palatine	Bldg. Rental

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	34	Rent	\$ 221,377	Plum Grove Healthcare Properties, LLC.	100.00%	\$	(221,377)	1
2	V	31	Amortization		Plum Grove Healthcare Properties, LLC.		25,650	25,650	2
3	V	32	Interest		Plum Grove Healthcare Properties, LLC.		189,903	189,903	3
4	V	30	Depreciation		Plum Grove Healthcare Properties, LLC.		58,130	58,130	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 221,377			\$ 273,683	\$ * 52,306	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number      The Plum Grove of Palatine      #      0038794      Report Period Beginning:      01/01/00      Ending:      12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Tamar Abell	Asst. Administrator	Administrative	15.00	28,000	13.25	26.50	Salary	\$ 30,000	17-1	1
2	Joseph Brandman	Asst. Administrator	Administrative	7.50	55,475	8.5	17.25	Salary	27,897	17-1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 57,897		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME;  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number The Plum Grove of Palatine# 0038794

Report Period Beginning:

01/01/00Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( \_\_\_\_\_ ) \_\_\_\_\_

Fax Number ( \_\_\_\_\_ ) \_\_\_\_\_

1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8  Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Pacific Life		X	Mortgage	\$18,448.00	11/17/95	\$ 2,220,000	\$ 2,086,156	11/17/15	8.0000	\$ 189,903	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$18,448.00		\$ 2,220,000	\$ 2,086,156			\$ 189,903	9	
	B. Non-Facility Related*												
10	Interest Income		X								(9,960)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (9,960)	14	
15	TOTALS (line 9+line14)						\$ 2,220,000	\$ 2,086,156			\$ 179,943	15	

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Facility Name & ID Number **The Plum Grove of Palatine**# **0038794**

Report Period Beginning:

**01/01/00**

Ending:

**12/31/00****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	<b>166,639</b>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	<b>163,397</b>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>(3,242)</b>	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>169,115</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<b>165,873</b>	7

  

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	<b>155,017</b>	8		
	1996	<b>159,032</b>	9		
	1997	<b>162,112</b>	10	13	FROM R. E. TAX STATEMENT FOR 1999 \$
	1998	<b>161,004</b>	11	14	PLUS APPEAL COST FROM LINE 5 \$
	1999	<b>163,397</b>	12	15	LESS REFUND FROM LINE 6 \$
				16	AMOUNT TO USE FOR RATE CALCULATION \$

**Line 4: 163397 x 1.035**

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**



Facility Name & ID Number    The Plum Grove of Palatine#    0038794

Report Period Beginning:

01/01/00

Ending:

12/31/00**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	69		1995		\$ 966,189	\$ 24,774	39	\$ 24,774		\$ 126,967	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Various Improvements			1993	11,986	306	39	306		2,297	9
10	Decorating			1993	17,180	439	39	439		3,296	10
11	Decorating			1993	16,183	414	39	414		3,106	11
12	Windows			1994	27,300	700	39	700		4,492	12
13	Air Conditioner			1994	29,179	748	39	748		4,924	13
14	Air Conditioner			1994	4,300	110	39	110		724	14
15	Painting			1994	3,725	96	39	96		632	15
16	Sign			1994	3,844	48	39	48		345	16
17	Wallpaper			1995	7,000	179	39	179		1,025	17
18	Floor			1995	7,810	200	39	200		1,142	18
19	Air Conditioner			1995	4,300	110	39	110		601	19
20	Remodeling			1995	5,625	144	39	144		810	20
21	Door Installation			1995	3,800	97	39	97		546	21
22	Exhaust Ventilator			1996	3,564	91	39	91		406	22
23	New Roof			1998	17,230	442	39	442		1,123	23
24	Tilework			1998	4,248	109	39	109		277	24
25	Cummins Generator			1998	73,600	1,887	39	1,887		4,482	25
26	Decorating			1998	54,647	1,401	39	1,401		3,911	26
27	Floor			1999	16,855	432	39	432		669	27
28	Remodeling			2000	6,276	87	39	87		87	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	<b>TOTAL (lines 4 thru 35)</b>				\$ 1,284,841	\$ 32,814		\$ 32,814		\$ 161,862	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 411,616	\$ 37,890	\$ 41,161	\$ 3,271	10	\$ 227,874	37
38	Current Year Purchases	17,279	17,279	864	(16,415)	10	864	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$ 428,895	\$ 55,169	\$ 42,025	\$ (13,144)		\$ 228,738	41

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 1,892,757	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 87,983	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 74,839	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ (13,144)	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 390,600	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.





**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**

<p><b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	--	---

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$ \_\_\_\_\_

**D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$		
	Licensed Speech and Language Development Therapist		hrs								2
2	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
10	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			\$		\$	\$		\$		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 229,589	\$ 231,070	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	144,507	144,507	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	56,348	56,348	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Real Estate Escrow	101,774		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 532,218	\$ 431,925	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		179,021	13
14	Buildings, at Historical Cost		966,189	14
15	Leasehold Improvements, at Historical Cost	318,653	318,653	15
16	Equipment, at Historical Cost	83,894	428,895	16
17	Accumulated Depreciation (book methods)	(108,956)	(530,888)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		392,725	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(139,380)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Due from Owners		99,305	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 293,591	\$ 1,714,520	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 825,809	\$ 2,146,445	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 120,706	\$ 120,706	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	51,371	51,371	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,552	5,552	31
32	Accrued Real Estate Taxes(Sch.IX-B)	169,115	169,115	32
33	Accrued Interest Payable		11,382	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 346,744	\$ 358,126	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,086,156	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$ 2,086,156	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 346,744	\$ 2,444,282	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 479,065	\$ (297,837)	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 825,809	\$ 2,146,445	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>436,040</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>436,040</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>143,025</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(100,000)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>43,025</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>479,065</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

**VII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 2,505,764	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,505,764	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	9,960	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 9,960	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,515,724	30

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	402,012	31
32	Health Care	1,052,062	32
33	General Administration	453,134	33
	<b>B. Capital Expense</b>		
34	Ownership	427,609	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers		35
36	Provider Participation Fee	37,882	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,372,699	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	143,025	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 143,025	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number The Plum Grove of Palatine# 0038794Report Period Beginning: 01/01/00Ending: 12/31/00

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	960	1,099	\$ 24,325	\$ 22.13	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,512	14,647	243,241	16.61	3
4	Licensed Practical Nurses	6,379	6,768	115,658	17.09	4
5	Nurse Aides & Orderlies	39,642	41,301	513,277	12.43	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,006	4,289	39,796	9.28	10
11	Social Service Workers	1,072	1,166	14,233	12.21	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,102	31,072	14.78	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,458	12,195	91,359	7.49	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	6,822	7,357	50,981	6.93	18
19	Laundry	2,014	2,178	16,200	7.44	19
20	Administrator	2,080	2,320	50,346	21.70	20
21	Assistant Administrator	3,790	3,797	57,897	15.25	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,110	2,363	28,236	11.95	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,000	2,080	15,685	7.54	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	97,925	103,662	\$ 1,292,306 *	\$ 12.47	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	120	\$ 5,005	1-3	35
36	Medical Director	60	1,800	9-3	36
37	Medical Records Consultant	30	825	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	84	3,165	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	66	2,851	11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	360	\$ 13,646		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53





**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).**

(See instructions.)

[illegible]

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. ICLTC-2705
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 39
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,500 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 37,882  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 3,500 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? \_\_\_\_\_  
d. Have vehicle usage logs been maintained? No  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? No  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.